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ABSTRACT

This paper describes 10 common characteristics of suicide that pertain to suicide committed at any age. Each characteristic is defined and analyzed, with specific approaches to treatment identified. The 10 characteristics, based on clinical experience and the relevant work of others, are listed. The commonalities discussed include: (1) the common purpose of suicide (to seek a solution); (2) the common goal of suicide (cessation of consciousness); (3) the common stimulus (psychological pain); (4) the common stressor (frustrated psychological needs); (5) the common emotion (hopelessness-helplessness); (6) the common internal attitude toward suicide (ambivalence); (7) the common cognitive state (constriction); (8) the common action (escape); (9) the common interpersonal act (communication of intention); and (10) the common consistency in suicide (lifelong coping patterns). Several hypotheses are proposed about the implications of this view of suicide for public policy. The hypotheses suggest that the more identifiable the risk, the more targeted will be the public response to relieve it; the more focused the political activity on behalf of potential victims, the more intense will be the public policy on that general topic; the more elevated the status of the potential victims, the more intense will be the public policy response (or vice versa); and the more congruent the prevention strategies are with current political and policy trends, the more active will be the public response on that topic. (ABB)

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Invited Address

Division of Child, Youth and Family Services

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TEN COMMONALITIES OF SUICIDE AND
SOME IMPLICATIONS FOR PUBLIC POLICY

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The conventional view of life, of the human life course from birth to death at old age, the view reflected both in contemporary developmental psychology and in everyday speech involves or implies such categories as infancy, childhood, youth, adolescence, young adulthood, middle-age, and old age. This view (and this language) obviously reflects a notion of human life organized into a finite number of different successive stages. In our language, the best known expression of this linear view of life is Jacques speech (Act II, scene vii) in Shakespeare's As You Like It. Everyone knows it: "All the world's a stage, and all the men and women merely players; They have their exits and their entrances, and one man in his time plays many parts, his acts being seven ages." Briefly paraphrased, they are the infant, the schoolboy, the young lover, the manful soldier, the middle aged justice, the senior citizen with spectacle and slippers and, last of all, the old man in second childhood, without teeth, vision, taste or anything, a sort of benign Alzheimerian state. In our time, Erik Erikson, with great psychodynamic sophistication, has translated Shakespeare's idea into eight psycho-social stages. Every non-experimental psychologist knows these by heart. In my own special field, suicidology, we have special efforts for suicide among the aged, adults, children suicide; and today's rage, with some understandable justification (and with some misdirection) is suicide among youth.

Standing somewhat aside from this Shakespearean view of life's stages is the view of the human life cycle. This view is enunciated best, at least to my ears, by the greatest psychologist-author in the history of America: Herman Melville. As an aside, Melville read and studied and understood Shakespeare's great plays with a

profundity that few men can claim). But in this matter of stages, Melville took a position radically different from Shakespeare and, to bring it up to date, somewhat at odds with much of contemporary academic psychology. Let us listen to what is an almost off-hand paragraph in a quiet chapter, Chapter 114 called "The Gilder," that holds the essence of an important thought

"Oh, grassy glades: oh ever vernal endless landscapes in the soul." I cannot resist interrupting myself to say that in the very first paragraph of Moby-Dick Melville, in one unforgettable phrase tells us what suicide is: "...it is a damp, drizzly November in the soul...." Now back to "The Gilder:" "...In ye, men may yet roll, like young horses in the new morning clover; and for some fleeting moments, feel the cool dew of the life immortal on them. Would to God these blessed calms would last. But the mingled, mingling threads of life are woven by warp and woof: calms crossed by storms, a storm for every calm. There is no unretracing progress in this life: we do not advance through fixed gradations, and at the long one pause: -- through infancy's unconscious spell, boyhood's thoughtless faith; adolescence' doubt, then skepticism, then disbelief, resting at last in manhood's pondering repose of If. But once gone through, we trace the round again /and again/: and are infants, boys and men and Ifs eternally. Where lies the final harbor, whence we unmoor no more? ...the secret...lies in the grave, and we must there to learn it."

In this one extraordinary paragraph, Melville outlines, using a cosmological example, a spiral, cyclical view of human development; a never-ending interplay of unconscious forces set down early in life and then forever after (until death) omnipresently active in one way or another. Human growth and human self destruction -- the capacity for amazement, insight, new knowledge and setting of ultimate limits is never over while one is still alive; and death, even when it is self-inflicted, always catches us with an incomplete agenda. The unconscious needs, having been laid down early and deep, are never totally satisfied and fulfilled. That -- and the conflicts generated from those early tensions -- is the main drama of life.

Without question these deep unity thema wax and wane over the course of a life -- and some times, or epochs, or eras, or stages of life, phenotypically speaking, have their own problems, trials, challenges, tasks, burdens and mysteries. And that, I believe is true through the course of a life, no matter how long it is lived.

As for a choice between the linear "life stagers" and the "life spiralists" I myself chose both. Using the example of suicide, there undoubtedly are some (and in my opinion, the most important) things to be said about suicide at any age; and, at the same time, there are some relevant, important, and clinically useful

things to be said about suicide at specific ages or times of life, like being nineteen, in college, fighting for grades, having been jilted in a first love. Both Shakespeare and Melville are on my shelf -- side by side -- and I would not willingly part with either of them.

I have elected to make these prolix introductory remarks -- with your great patience -- because I wish to speak about the common characteristics of suicide, the ubiquitous features, the desiderata that pertain to committed suicide from age six to age 96, those spiraling elements that can appear (and I believe, do appear) at any stage of life.

Alas, before I proceed directly to the common characteristics of suicide I must beg your indulgence for one more iconoclastic aside. Concerning the field of suicide, it is almost impossible nowadays to say anything without leaning rather heavily on the shoulders of two great intellects who seem to have dominated the field: Durkheim and Freud. Nor would there be any point in eschewing the traditional sociological and psychoanalytic positions simply for the sake of doing so. Nevertheless, in what I have attempted to develop about suicide I have consciously tried not to be a burden to either of these giants. My problem was: How to think afresh about age-old suicide without becoming involved in either the aridity of "anomie" or the entanglements of "hostility directed toward the introjected ambivalently viewed love object?" I have tried to make some new beginnings.

My years of direct clinical experience with suicidal persons and with psychological autopsies and my own reflections about suicide led me to three pillars of a possible new approach, each of which rested on a solid golden volume. The three pillars or mainstays are: a suicidal person's philosophy of life, feelings about the meaning of life, life's hold on him, his notions of death; in a word; his cosmology. The second was the suicidal person's, I dare to say personality, especially the disposition of his or her psychological needs and threshold for their frustration and thwarting, related to a limen for psychological pain; in a word personology. And third, a way for me, the theoretical suicidologist, to put together everything that I believed to be relevant to a living system that has destroyed itself; in a word, systems theory.

Time does not permit me to do so, but I should like to give a separate lecture on each of the three great books that form the tripartite base of the presentation to follow.

I consider them to be the best books available for my purposes. For philosophy and cosmology, Stephen Pepper's comprehensive 1942 World Hypotheses; for personology, one of psychology's half-dozen greatest books, Henry A. Murray's 1938 Explorations in Personality; and for systems theory, James G. Miller's monumental 1978 Living Systems. (I have lunch with Jim Miller a few times each month and I shall be with Harry Murray, now a robust 92

within a few weeks.) These books -- none of them about suicide -- have provided for me, in combination, special windows to what I hope is a somewhat new look at this age-old topic.

The most interesting question about suicide is: What is common to committed suicide? That is: What are the interesting, relevant dimensions, the common features or characteristics of suicide that can be delineated from a common sense point of view, especially when based on clinical experience and enlightened by the relevant, seminal work of others?

A few words about that word "common" may be helpful. Each suicide is an idiosyncratic event. In suicide, there are no universals, absolutes, "alls." I am convinced that the search for a universal formulation for all suicide is a chimera. The best that one can reasonably hope to discuss are the most frequent (common) characteristics that accrue to most suicides, and to make this discussion in as common sense and ordinary (and thus catholic) language as possible.

Here -- as the body of my contribution -- are some salient characteristics -- the ten commonalities -- of suicide.*

I. The common purpose of suicide is to seek a solution.

First of all, suicide is not a random act. It is never done pointlessly or purposelessly. It is a way out of a problem, a dilemma, a bind, a challenge, difficulty, crisis, an unbearable situation. It has an inexorable logic and impetus of its own.

*From E. Shneidman, Definition of Suicide. (NY: Wiley, 1985).

It is the answer -- the only available answer -- to a real puzzler: How to get out of this? What to do? Its purpose is to solve a problem; to seek a solution to a problem generating intense suffering.

The well-known English novelist and essayist, John Fowles, early in his career, wrote a brilliant set of aphorisms, called The Aristos. The Greek word aristos means the best possible solution in a given situation. The dozen or so individuals whom I have talked to, who, in one way or another, actually committed suicide and fortuitously survived -- immolating, jumping, shooting -- have all, to paraphrase them, said something like this: It was the only thing I could do. It was the best way out of that terrible situation. It was the answer to the problem I had to solve. I couldn't see any other way.

In this sense every suicide is an aristos; every suicide has as its purpose the seeking of a solution to the perceived problem. To understand what a suicide was about, one has to know the problem it was intended to solve. All this ties to my definition of suicide: Suicide is the conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the act is perceived as the best solution.

In Dante's Commedia there are nine poetically described descending circles in the Inferno to the ultimate devilish pit. In the real hell of life, the levels of misery seem endless; there is searing joylessness. Something worse than one's present awful state can be imagined. And it is that "something worse" that we fear. That is the common fear: the more pain, more degradation, more tension, more shame, more guilt, more terror, greater hopelessness, more insanity, something far worse, like having to survive and face the next day. To the extent that suicide is an act to solve a problem, the common fear that drives it is the fear that the situation will deteriorate, become much worse, get out of hand, exacerbate beyond the point of any control. Better dead than mad. We have heard from the past generation of youths (and from psychologists) of ultimate moments, peak experiences, total actualization, complete emotional states, but life is much more realistically understood in terms, not of superlatives, but of comparatives. What we fear is something worse than what we have. Oftentimes, persons literally on the ledge of committing suicide would be willing to live if things, life, were only just a little bit better; a just-noticeable-difference more tolerable. The common fear is that the Inferno is bottomless. We reason that we have to draw the line on interbal suffering somewhere. Every suicide makes this statement: This far and no further -- even though he would have been willing to live on the brink.

II. The common goal of suicide is cessation of consciousness.

In a curious and paradoxical way, suicide is both a moving toward and a moving away from something; the something that it is moving toward, the common practical goal of suicide is the stopping of the painful flow of consciousness. Suicide is best understood not so much in relation as a moving toward the idea of a reified Death, as it is in terms of the idea (in the mind of the suicidal person) of "cessation," specifically when cessation -- the complete stopping of one's consciousness of unendurable pain -- is seen by the suffering individual as a solution, indeed the perfect solution, of life's painful and pressing problems. The moment that the idea of the possibility of stopping consciousness occurs to the anguished mind as the answer or the way out -- in the presence of the three essential ingredients of suicide -- unusual constriction and elevated perturbation and high lethality, then the igniting spark has been added and the active suicidal scenario has begun.

III. The common stimulus (or information input) in suicide is psychological pain.

If cessation is what the suicidal person is moving toward, pain is what that person is seeking to escape. In any close analysis, suicide is best understood as a combined movement toward cessation and a movement away from intolerable emotion, unendurable pain, unacceptable anguish. No one commits suicide out of joy; no suicide

is born out of exaltation. The enemy to life is pain and, when pain does not come from one's own soma, then the threateners of life are those who cause the pain. It is psychological pain of which we are speaking; metapain; the pain of feeling pain. The clinical rule is: Reduce the level of suffering, often just a little bit, and the individual will choose to live. Suicide is not a biological event to be treated only by physicians -- that is both hubris and nonsense; suicide is a human condition of psychological pain to be addressed by anyone who can, through psychological or other techniques, befriending or changes in the real world, mollify the psychological pain that the sufferer is experiencing.

IV. The common stressor in suicide is frustrated psychological needs.

Suicide is best understood not so much as an unreasonable act -- every suicide seems logical to the person who commits it given that person's major premises, styles of syllogizing, and constricted focus -- as it is a reaction to frustrated psychological needs. A suicide is committed because of thwarted, blocked or unfulfilled needs.

In order to understand suicide in this kind of context, we need to ask a much more broad question, which, I believe, is the key: What purposes do most human acts in general intend to accomplish? The best non-detailed answer to that question is that,

in general, human acts are intended to satisfy a variety of human needs. There is no compelling a priori reason why a typology (or classification or taxonomy) of suicidal acts might not parallel a classification of general human needs. Indeed, such a classification of needs exists. It can be found in Murray's Explorations in Personality. There, in Murray's list of human needs -- they include the need for achievement, affiliation, autonomy, counteraction, defendance, harmavoidance, inviolacy, and succorance -- is a ready-made, viable, useful taxonomy of suicidal behaviors.

Most suicides probably represent combinations of various needs, so that a particular case of suicide might properly be subsumed under two or even three different need categories.

There are many pointless deaths, but there is never a needless suicide. Address the frustrated needs and the suicide will not occur.

The therapist's function is to help the patient in relation to the thwarted needs. Even a little bit of improvement can save a life. In general, the goal of psychotherapy is to increase the patient's psychological comfort. One way to operationalize this task is to focus on the thwarted needs. Questions such as "What is going on?" "Where do you hurt?" and "What would you like to have happen?" can usefully be asked by a therapist helping a suicidal person.

V. The common emotion in suicide is hopelessness-helplessness.

At the beginning of life the common emotion is probably randomized general excitement. In the suicidal state it is a pervasive feeling of helplessness-hopelessness. There is nothing that I can do (except to commit suicide) and there is no one who can help me (with the pain that I am suffering). I believe that this formulation permits us somewhat gracefully to withdraw from the (sibling) rivalry among the various emotions, each with the proponents to assert that it -- hostility, shame, guilt, depression, etc. -- is the central of them all. Historically -- in the 20th century, that is -- hostility was the eldest brother. Stekel said so in the 1910 meeting of the Psychoanalytic Society in Vienna; No man kills himself except as he fantasized the death of another. And then, in a somewhat more ornate phrase: Suicide is essentially hostility directed toward the (ambivalently viewed) introjected love object. One would plunge a knife into one's chest in order to expunge or kill the internalized homunculus of the loved-hated father within -- what I once called murder in the 180th degree.

But today we suicidologists know that there are other deep basic emotions. The early psychoanalytic formulations are seen as a brilliant hypothesis, more pyrotechnical than universal.

But underlying all of these -- and others that might be mentioned -- is that emotion of active, impotent ennui, the feeling of hopelessness-helplessness.

VI. The common internal attitude toward suicide is ambivalence.

One does not ordinarily think of Freud as a giant in the history of logic but, in a way, he made as enormous an impact in extending our understanding of our cognitive maneuvers as perhaps Bacon, Mill and Russell. Western logic is Aristotelian. Aristotle's logic is dichotomous; it is binary. A term is either A or non-A. An inference is either true or false; a mood of the syllogism is either valid or invalid; an idea is either logical or illogical.

Freud brought to our unforgettable attention the psychological truth (that transcends the Aristotelian appearance of the neatness of logic) that something can be both A and non-A. We can both like and dislike the same person; we can both love and hate the same person. It is an Aristotelian question to say Make up your mind! The answer is that we are of two minds, at least. We can now assert that the prototypical suicidal state is one in which an individual cuts his throat and cries for help at the same time, and is genuine in both of these acts. This non-Aristotelian accommodation to the psychological realities of mental life -- ambivalence -- is the common internal attitude toward suicide: To feel that one has to do it and, simultaneously, to yearn for rescue and intervention.

It makes more sense to discuss this all-too-human conflict in concrete and effective terms and to answer the cruel question, why not let him? by asking the practical counter question: Why not reduce the level of his unbearable stress? In effect, why not be a good Samaritan and do some things, quite simple things, inexpensive things -- like talking to some people, making some arrangements, contacting some agencies, manipulating some intransigent people in the suicidal person's behalf. What the suicidal person requires is only the efforts of a benignant person, an ombudsman, a champion.

VII. The common cognitive state in suicide is constriction.

I am not one who believes that suicide is best understood as a psychosis, a neurosis or a character disorder. I believe that it is much more accurately seen as a more-or-less transient psychological constriction of affect and intellect. Synonyms for constriction are a tunnelling or focussing or narrowing of the range of options usually available to that individual's consciousness when the mind is not panicked into dichotomous thinking: either some specific (almost magical) total solution or cessation; all or nothing; Caesar aut nihil, to quote from Binswanger's famous case of Ellen West.

The usual life-sustaining images of loved once are not disregarded. Worse, they are not even within the range of what is in the mind. A person who commits suicide turns one's back on the past, declares bankruptcy and memories to be unreal. They can no longer help or save; one is beyond their reach. Any attempt at rescue or remediation has to deal almost from the first with the pathological constriction.

This fact, that suicide is committed by individuals who are in a special constricted condition leads us to suggest that no one should ever commit suicide while disturbed. It is not a thing to do while one is not in one's best mind. Never kill yourself when you are suicidal. It takes a mind capable of scanning a range of options greater than two to make a decision as important as taking one's life. Dichotomous slogans like Death Before Dishonor, Live Free or Die, or Give Me Liberty or Give me Death all have some emotional appeal, but they are not sensible or wide-ranged enough to be prescriptions for making it through life.

It is vital to counter the suicidal person's constriction-of-thought by attempting to widen the mental blinders and to increase the number of options, certainly beyond the two options of either having some magical resolution or being dead.

An example may be useful. A teenage college student, demure, rather elegant (and somewhat wealthy) was encouraged to come to see me. She was single, pregnant and suicidal, with a formed suicidal plan. Her challenge to me was that I somehow, magically, had to arrange for her to be the way she was before she became pregnant, virginal in fact, or she would have to commit suicide. Her being pregnant was such a mortal shame to her, combined with strong feelings of rage and guilt, that she simply could not "bear to live." At that moment suicide was the only alternative for her.

I did several things. For one, I took out a sheet and -- to begin to "widen her blinders" -- said something like, "Now, let's see: You could have an abortion here locally." ("I couldn't do that.") (It is precisely the "can'ts" and the "won'ts" and "have to's" and "nevers" and "always" and "onlys" that are negotiated in psychotherapy.) "You could go away and have an abortion." ("I couldn't do that.") "You could bring the baby to term and keep the baby." ("I couldn't do that.") "You could have the baby and adopt it out." ("I couldn't do that.") "We could get in touch with the young man involved." ("I couldn't do that.") "We could involve the help of your parents." ("I couldn't do that.") and "You can always commit suicide, but there is obviously no need to do that today." (No response.) "Now, let's look at this list and rank them in order of your preference, keeping in mind that none of them is optimal."

The very making of this list, my nonhortatory and nonjudgmental approach already had a calming influence on her. Within a few minutes her lethality had begun to deescalate. She actually rank-ordered the list, commenting negatively on each item. What was of critical importance was that suicide was now no longer ranked first or second. We were then simply "haggling" about life -- a perfectly viable solution.

The point is not how the issue was eventually resolved or what interpretations were made as to why she permitted herself to become pregnant, other aspects of her relationships with men, etc. What is important is that it was possible to achieve the assignment of that day: to lower her lethality by reducing her perturbation by widening her range of "logical" and realistic options from only the choice between suicide and one other choice.

In addition it is important to keep in mind that there is a latent syllogism in every suicide. The therapist should know what it is (in its manifest form) and should gently but firmly reject it by every interpretation and comment that is made to the suicidal person. Just as one does not collude with a suicidal person in fact, one should not collude with a suicidal person in logic.

In working with a suicidal person it may be vital not to "buy into" his major premise (because all his suicidal solutions flow from that) -- but I certainly do not mean that one should argue or dispute the premise directly. Still, the key lies in not accepting the person's suicidal syllogism, his premises and his lethal conclusion.

VIII. The common action in suicide is escape (egression).

Egression is a person's intended departure from a region of distress. Suicide is the ultimate egression, besides which running away from home, quitting a job, deserting an army, leaving a spouse, pale. Erving Goffman spoke of unpluggings: having a good read, darting into a movie, going for a weekend at Las Vegas or Atlantic City, benign egressions all. But we must distinguish between the wish to get away and the need to end it all, to stop it for real. The point of suicide is a radical and permanent change of scene; the action to effect it is to leave.

Here is an excerpt from a letter, dated March 26, 1921, from Violet Keppel Trefusis to her lover Vita Sackville-West, then in the eighth year of her unusual bisexual marriage to Harold Nicolson. (Nigel Nicolson, Portrait of a Marriage. New York: Atheneum, 1972).

I am dead with grief. I am utterly alone. You cannot want me to suffer so. You had to choose between me and your family, and you have chosen them. I do not blame you. But you must not blame me if one day I seek for what escape I can find.

That passage is an operational definition of what, at rock bottom, from the suicidal person's point of view, suicide is: "...what escape I can find." In that brief quotation from the letter, one can see intimations of several common characteristics of suicide: the wish for cessation, the need to stop pain, the sense of hopelessness, the presence of constriction, and the search for escape -- as well as the communication of the intent.

IX. The common interpersonal act in suicide is communication of intention.

One of the most interesting findings from large number of psychological autopsies of clearly suicidal deaths was that there were clues to the impending lethal event present in approximately eighty percent of suicidal deaths. Individuals intent on committing suicide, albeit ambivalently minded about it, consciously or unconsciously emit signals of distress, whimpers of helplessness, pleas for response, opportunities for rescue in the usually dyadic interplay that is an integral part of the suicidal drama. It is a sad and

paradoxical thing to note that the common interpersonal act of suicide is not hostility, not rage or destruction, not even withdrawal, not depression, but communication of intention.

Everyone in suicidology now knows the usual clues, verbal and behavioral: The verbal statements are tantamount to saying I am going away (egression), you won't be seeing me, I cannot endure it (pain) any longer; the behavioral signs are such unusual acts as putting affairs in order, giving away prized possessions and, more generally, behaving in ways that are different from usual behaviors that betoken a bubbling (as a cauldron bubbles) in a perturbed psyche.

The communication of suicidal intention is not always a cry for help. First, it is not always a cry; it can be a shout or a murmur or the loud communication of unspoken silences. And it is not always for help; it can be for autonomy or inviolacy or any of a number of other needs. Nonetheless, in most cases of suicide, the common penultimate act is some interpersonal communicative exchange related to that intended final act.

X. The common consistency in suicide is with life-long coping patterns.

People who are dying over weeks or months of a disease, say cancer, are very much themselves, even exaggerations of their normal selves. Contrary to some currently popular notions in paper-back

thanatology, there is not any standard set of stages in the dying process through which individuals are marched., lock-step, to their deaths. In terms of emotions displayed (rage, acceptance, etc.) or mechanisms of psychological defense manifested (projection, denial, etc.) one sees a full panoply of both of these arranged in almost every conceivable number and order. What one does see in almost every case, I believe, are certain consistencies of display of emotion and use of defense that are consistent with that individual's microtemporal, mesotemporal and macrotemporal reactions to pain, threat, failure, powerlessness, duress in previous earlier episodes of that life. People dying are enormously consistent with themselves. So are suicidal people. So are people who are neither dying nor suicidal.

In suicide, we are initially thrown off the scent because suicide is an act, by definition, which that individual has never done before, so there is no precedent. And yet there are some consistencies with life-long coping patterns. We must look to previous episodes of disturbance, to capacity to endure psychological pain, to the penchant for constriction and dichotomous thinking, for earlier paradigms of egression.

I speak with a tiny bit of experimental authority on this issue, at least with a sense of conviction that flows from the data I examined. Very briefly, in a study of a group of men who were about fifty-five years old, each of whom had been studied rather

intensively on a continual basis since he was about six years old -- I am referring here to the well-known Terman longitudinal study of the gifted, begun in 1920, with 1,528 young male and female subjects and continuing to this date at Stanford University under the direction of Professor Robert Sears. In my bite-size study, other than the demonstration that it was possible (beyond chance expectation) to select the five subjects who had committed suicide from a group of thirty cases, the main finding was that -- working as I did, from a detailed life-chart which I constructed for each individual -- the determination that the person would (or would not) commit suicide at around age fifty-five could be made by me before the thirtieth birthday in each man's life. There were already certain psychological consistencies within the life, certain characteristics or habitual patterns of reactions for that person to threat, pain, pressure, failure which made dire predictions of a tragic suicidal outcome at fifty-five an almost straightforward logical and psychological extrapolation.

In light of the enormous unpredictability of life, what impresses and excites me as a psychologist is how much of a person's life, in some of its more important aspects, is reasonably predictable. In general, I feel this way about suicide. It is enormously complicated, but it is not totally random and it is amenable to some prediction. That is our main handle on individual prevention.

That completes my current list of the ten common characteristics of suicide.

Now a few final words about implications of this view of suicide for public policy. On this sub-topic, the following hypotheses are proposed:

(a) The more identifiable the risk, the more targeted will be the public response to relieve it. It follows that suicidologists have a clear responsibility to identify, delineate and disseminate (in ordinary language) the common clues to suicide -- without using terms like premonitory signs or prodromal symptoms.

(b) The more focused the political activity on behalf of potential victims, the more intense will be the public policy on that general topic. In this sense, it makes good tactical sense to focus for the present on perhaps the most dramatic and tragic of all suicides (as a group), namely suicide among the young.

(c) The more elevated the status of the potential victims, the more intense will be the public policy response (or vice versa). We are not egalitarian about death: we mourn the death of a talented or beautiful or young person more than their converse; so, again, there is a strategic point to an emphasis on youth suicide prevention. Nor is there anything nefarious in this.

(d) The more congruent the prevention strategies are with current political and policy trends, the more active will be the public response on that topic. In this connection, we, as

psychologists and suicidologists must keep in mind the cold and sobering socio-political fact that more liberal federal leadership tends, in general, to tolerate and support sociological and psychological approaches to what are called social problems (of which suicide is clearly one); while, conversely, more conservative federal leadership such as we have at present, tends to support non-psychological approaches, specifically in the case of suicide, biological and medical solutions. Of course, I believe in medications that work to dispell depressive affect, but the medicalizing of what is essentially a psychological malaise is, in some of its effects, an intellectually wrong-minded enterprise. There is no coccus, spirochete or virus for human conation. Suicide is not a disease like measles or AIDS. Thus, the dramatis personae along the Potomac are very relevant to public policy on suicide prevention.

In conclusion: Most people would agree that the best prevention is primary prevention. Primary prevention of suicide lies in education -- and I don't mean our present Office of Education. The route is through teaching one another and that large amorphous group known as the public that suicide can happen to anyone, that there are discernible desiderata (if one but has the perspacacity to see and hear them when they occur) and that help is available. The main task lies in the dissemination of information, especially about the clues to suicide: in schools, in the workplace and very selectively through the public media. In the end, effective prevention of suicide is everybody's business.

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